

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3429-62-023135
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED JUL 16 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 14 YRS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR SIDEWALK IN FRONT OF INSTITUTION 1516 BROADWAY		d. STREET ADDRESS (If outside, give location) 503 W. 16th	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES D HURSMAN		4. DATE OF DEATH Month Day Year 6 28 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-8-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY SAFEWAY CO.	11. BIRTHPLACE (City and state or country) DOVER MISSOURI
13a. FATHER'S NAME JAMES HURSMAN		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE EVA HURSMAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT JOHN ROBERT HURSMAN 2707 HARRISON	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Hugh H. Owens		22b. ADDRESS 152 Union Station	22c. DATE SIGNED 6-29-62
23a. BURIAL, CREATION, REMOVAL (Specify) BURIAL	23b. DATE July 2 1962	23c. NAME OF CEMETERY OR CREMATORY DOVER CEMETERY	23d. LOCATION (City, town, or county) DOVER MISSOURI
24. FUNERAL DIRECTOR SHEIL FUNERAL HOME K.C. MO.	25. DATE RECD. BY LOCAL REG. 6-29-62	26. REGISTRAR'S SIGNATURE Ruth N Long	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Richard C. Carroll

Licensed Embalmer No.

4829

P. O. Address

R. C. Carroll

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.